SCAT/PARATRANSIT
RECERTIFICATION
APPLICATION

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13-0130P 12/11RY

OFFICE OF THE
SUFFOLK COUNTY EXECUTIVE
OFFICE FOR PEOPLE WITH DISABILITIES
BUILDING 158, NORTH COUNTY COMPLEX
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SCAT PARATRANSIT

RE-CERTIFICATION OVERVIEW

Enclosed is an application for **re-certification** for the Suffolk County Accessible Transit (SCAT) Paratransit system. You are receiving this because your SCAT **eligibility** is about to **expire**. SCAT is for people whose disability is so severe that it prevents them from using public buses. In compliance with the Americans with Disabilities Act of 1990 (ADA) Suffolk County provides curb-to-curb paratransit services for the SCAT Program to anyone who, because of physical or mental disability, is unable to use the regular, fixed route bus service. Age, distance from a bus stop, or inability to drive, are conditions which are not taken into consideration in making an eligibility determination.

This application form is intended to determine the circumstances under which the applicant can use the regular, fixed route bus system. Each application will be evaluated on a case-by-case basis, taking into consideration all of the information provided.

The applicant, or someone assisting him/her, must complete all the questions. A New York State licensed medical professional is required to complete the medical certification, this consists only of an M.D., P.A, N.P, D.O., or D.C. If you do not have access to a licensed medical professional, please call (631)853-8333 for assistance.

When you have completed and signed the application, mail it (original only, we will **not** accept photocopies or faxes of this application) and **two identical black and white, or color passport size photographs** (no photocopies) to:

Suffolk County Office for People with Disabilities
Building 158, North County Complex
P.O. Box 6100
Hauppauge, NY 11788-0099

You will be notified by mail of your re-certification three weeks after we receive your completed application. Meanwhile, if your card is not already expired, you may continue to use the SCAT Paratransit service.

The specifications for the two original photographs are: clear, full face, front view. Your face should fit in a 1" by 1 1/4" area, the size of the box below, just print your name on the back of each photo and attach them to the application.

On the other side of this cover letter is information about Paratransit. If you have any questions, or need assistance filling out the application, please feel free to call us at 853-8333 (voice), or if hearing impaired phone 853-5658 (TTY).

size of photo

Do Not
Paste
Photo
Here

REVISED SCAT-PARATRANSIT PROCEDURES & GUIDELINES 11/09

1) To make a trip reservation, call the Suffolk County Accessible Transit (SCAT) Paratransit dispatcher at 631-738-1150 (voice) or 631-981-0104 (TTY). ALL RESERVATIONS ARE SUBJECT TO AVAILABILITY. Riders are entitled to trips on a first-come, first-served basis.

2) Reservations may be made up to 7 days in advance and no later than one day prior to the day you want to ride, if available. Multiple reservations can be made at one time. Since reservations are on a first-come, first-served basis you may not always get the reservation you desire if those time slots have already been taken.

3) Reservations can be made between 7:00 a.m. and 5:00 p.m., Monday through Saturday. On Sundays, reservations can be made between 8:00 a.m. and 4:30 p.m. for next day travel only.

4) The first daily pick-up will be about 6:00 a.m. Monday through Friday, (7:00 a.m. on Saturday), and the last daily pick-up will be about 8:30 p.m. and later in those areas where SCT bus lines continue to operate later in the evening. **Please note that since there is no bus service on Sundays or on holidays, there is no Paratransit service on these days either.**

5) The fare is $3.00 one way ($6.00 round trip). **Exact fare is required.**

6) For riders requiring a personal care attendant (PCA), as shown on ID card, the attendant will travel free. In addition to the PCA, one companion can also accompany the rider by paying the full fare. Additional companions may also accompany the rider, but only if sufficient vehicle capacity can accommodate them and they each must also pay the full fare.

7) Riders must have their I.D. card with them when using SCAT identifying them as ADA Paratransit eligible. (If you do not yet have your ID card, bring your eligibility certification letter along on the trip).

8) If cancellation of your reservation is necessary, it must be made at least two (2) hours before your scheduled pick-up time. In an emergency, call as soon as possible. **However, riders who are repeat no shows or cancel excessively risk having their riding privileges suspended or revoked.**

9) Service is curb-to-curb. SCAT may also approve providing additional, limited assistance between curbside and a building's entrance along an accessible path when requested at the time trip reservations are made, in accordance with the Origin to Destination Policy.

10) Drivers are not required to carry packages for you. Maximum number of packages passengers are permitted to bring on a single boarding is determined on what they can safely carry on and off the vehicle. While on board the vehicle packages must be stored in a location that does not block path of travel within the vehicle, or interfere with safety features, or securement of others passengers.

11) All pick-up and drop-off locations must be within Suffolk County, NY. Trip origins and destinations must be within ¾ of a mile of a Suffolk County Transit or HART (for trips within Huntington) fixed bus route.

12) Please note the SCAT bus has a half-hour window, where it can show up 15 minutes before or 15 minutes after your scheduled pick-up time. **YOU MUST BE READY DURING THIS ENTIRE WINDOW BECAUSE THE BUS WILL NOT WAIT MORE THAN 10 MINUTES FOR YOU.**

13) If you are able to use the public bus system for any trips, we urge you to do so, to make room for people who can only travel via Paratransit. Thank you for your cooperation.

PLEASE SAVE!

SCAT PARATRANSIT APPLICATION FORM RECERT

PART 1. GENERAL INFORMATION

M ☐ F ☐ DATE OF BIRTH: ☐☐ / ☐☐ / ☐☐

LAST NAME | FIRST NAME | MI

STREET ADDRESS: | APT/BLDG #:

CITY: | COUNTY: | ZIP CODE:

HOME PHONE NUMBER ( ) -

WORK PHONE NUMBER ( ) -

NEAREST CROSS STREET

EMAIL: _____

MAILING ADDRESS: *If different from above*

STREET ADDRESS: | APT/BLDG #:

CITY: | COUNTY: | ZIP CODE:

1. Do you require information and material given to you in any of the following ways?

Mark all that you need

☐ Braille ☐ Large Print ☐ Audio Tape ☐ Other: _____

PLEASE GIVE US THE NAME AND TELEPHONE NUMBER OF SOMEONE WE CAN CALL IN AN EMERGENCY.

LAST NAME | FIRST NAME

HOME PHONE NUMBER ( ) -

WORK PHONE NUMBER ( ) -

DO NOT WRITE BELOW THIS LINE

CERTIFICATION DATA

ID# _____ DATE RECEIVED

Date Issued: _____

Expiration Date: _____

Eligibility Category: _____

Certifier: _____

Comments: _____

2. Please indicate below if you use any of the following mobility aides or equipment.

- ○ Cane
- ○ Crutches
- ○ long white cane (for the visually impaired)
- ○ service/guide animal (describe)_____
- ○ walker
- ○ leg braces
- ○ manual wheelchair
- ○ powered wheelchair
- ○ powered scooter/cart
- ○ respirator/oxygen tank
- ○ other _____
- ○ I don't require any assistive devices

Note: We may not be able to accommodate the applicant if the wheelchair or scooter is longer than 48 " or wider than 32 3/4", or if the combined weight of the applicant and wheelchair is more than 600 pounds.

PART 2. QUESTIONS ABOUT USING FIXED ROUTE BUSES

3. Have you ever used the fixed route buses?

- ○ *Yes, I* typically use fixed route buses _____ times a week.
- ○ Yes, but only for trips I am familiar with.
- ○ *Yes, I* used to but stopped because_____
- ○ *No*

4. If you currently do not use the fixed route is there something that might help you to ride the buses? (Mark all that apply.)

- ○ *Yes,* route and schedule information.
- ○ Yes, learning to use the buses.
- ○ Yes, if bus stops were closer to where I live and where I need to go.
- ○ Yes, (describe):_____
- ○ *No,* none of these would help.
- ○ *Yes,* buses with wheelchair lifts.
- ○ *Yes,* a communication aid.

5. How far from your home is the nearest bus stop?

- ○ Less than I block
- ○ 1-2 blocks
- ○ 3-4 blocks
- ○ 5 or more blocks
- ○ I don't know

6. On your own or using an assistive device, how far can you travel?

- ○ I can get to the curb in front of my house/apartment
- ○ I can travel up to 3 blocks (1 /4 mile)
- ○ I can travel up to 6 blocks (1/2 mile)
- ○ I can travel up to 9 blocks (3/4 mile)
- ○ I don't know.

SCAT PARATRANSIT APPLICATION FORM RECERT

7. Please mark ALL the disabilities that prevent you the applicant from using the fixed route.

☐ AIDS	☐ Kidney Disease/Dialysis
☐ Alzheimer's Disease	☐ Legally Blind
☐ Asthma	☐ Lupus
☐ Arteriosclerosis	☐ Macular Degeneration
☐ Arthritis	☐ Mental Retardation
☐ Autism	☐ Multiple Sclerosis
☐ Cancer	☐ Muscular Dystrophy
☐ Cataracts	☐ Other: _____
☐ Cerebral Palsy	☐ Panic Disorder
☐ Congestive Heart Failure	☐ Paraplegia
☐ COPD	☐ Parkinson's Disease
☐ Cortical Blindness	☐ Peripheral Vascular Disease
☐ Cystic Fibrosis	☐ Phobia
☐ Dementia	☐ Quadriplegic
☐ Diabetes (severe)	☐ Retinopathy
☐ Emphysema	☐ Schizophrenia
☐ Epilepsy (severe)	☐ Spina Bifida
☐ Heart Attack	☐ Stroke/Cerebral Trauma
☐ Head Trauma	☐ Thrombosis (chronic)
	☐ Totally Blind

8. How does your identified disability prevent you, the applicant from riding the fixed route buses? Please explain in DETAIL.

_____

_____

_____

_____

9. Is this condition permanent? YES NO

Is this condition temporary? YES NO

If temporary, what is the expected duration? _____
(Number of months)

10. Does the applicant need to travel with their own Personal Care Attendant (PCA)?

☐ Yes
☐ No
☐ Sometimes

11. Is the applicant able to travel to and from a bus stop?

Yes No

If no, please indicate all that apply:

☐ Cannot negotiate where there are no sidewalks?.
☐ Cannot travel if there are no curb cuts.
☐ Cannot cross busy streets and intersections.
☐ Cannot tolerate extreme temperatures.
☐ Cannot travel on surfaces covered with ice/snow.
☐ Cannot locate or identify bus stop due to a visual impairment.
☐ Easily becomes confused and may get lost.
☐ Other (please specify): _____

SCAT PARATRANSIT APPLICATION FORM RECERT

12. **Is the applicant able to perform the following functions without assistance from another person?**

	YES	NO
Find his/her way between familiar locations?	☐	☐
Grasp coins, passes, railings, and handles?	☐	☐
Climb up and down three 12 inch steps?	☐	☐
Travel 3/4 mile to a bus stop?	☐	☐
Identify the stop at your destination?	☐	☐
Deal with unexpected situations or unexpected changes in routine?	☐	☐

SCAT APPLICATION MEDICAL FORM

Dear Health Care Professional (M.D., D.O., P.A., N.P., or D.C. only):

You are being asked to provide information regarding this applicant's disability. The Federal Law is very specific about ADA Paratransit eligibility. The law restricts eligibility to individuals who:

1. As a result of their disability, cannot board, ride, or disembark from a regular bus or
2. Have a specific impairment-related condition which prevents them from getting to or from a bus stop or
3. Who need a wheelchair lift when a wheelchair lift-equipped bus is not available on the route that they need to travel.

PLEASE NOTE: This does not include persons who find it difficult or uncomfortable to get to and from bus stops. In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

This application is intended to determine whether the applicant can use regular transit service (fixed route) or whether he/she requires curb-to-curb service. Please exercise care in evaluating applicants. Your evaluation must be based solely upon the applicant's ability to use regular transit. Carefully evaluating these criteria will ensure that reliable Paratransit service is available for those who truly require it. This form must be completed in its entirety; any question left blank will deem this form **void** and incomplete. Please write clearly and legible.

Please mark all the disabilities which prevent the applicant from using the fixed route bus service. Conditions which make it difficult or uncomfortable should not be checked.

The health care professional completing this application certifies that **_____ (Name of applicant),** is a severely disabled person whose functional limitation is:

1) Neuromuscular
( ) Amputation of (specify)_____
( ) Cerebral Palsy
( ) Muscular Dystrophy
( ) Parkinson's Disease
( ) Spina Bifida
( ) Stroke
( ) Brain Injury
( ) Quadriplegia
( ) Multiple Sclerosis
( ) Paraplegia
( ) Polio
( ) Arthitis
( ) Other:_____
( ) None

2) Cardiovascular
( ) Arteriosclerosis
( ) Asthma
( ) Cystic Fibrosis
( ) Heart Attack
( ) Emphysema
( ) Congestive Heart Failure
( ) Chronic Obstructive Pulmonary Disease
( ) Peripheral Vascular Disease
( ) Thrombosis (Chronic)
( ) Other:_____
( ) None

3) Vision (mark all that apply)	**One Eye**	**Both Eyes**
Cataracts	( )	( )
Glaucoma	( )	( )
Macular Degeneration	( )	( )
Retinal Detachment	( )	( )
Retinopathy	( )	( )
Totally Blind	( )	( )
Legally Blind	( )	( )
Other:_____		
None	( )	

4) General Medical
( ) AIDS
( ) Diabetes (severe)
( ) Cancer
( ) Lupus
( ) Epilepsy (severe)
( ) Kidney Disease/Dialysis
( ) Other: _____
( ) None

Please note: Only the original forms of this document will be accepted.

SCAT APPLICATION MEDICAL FORM

5) Cognitive/Psychological
( ) Alzheimer's Disease
( ) Autism
( ) Dementia
( ) Head Trauma
( ) Mental Retardation
( ) Schizophrenia
( ) Anxiety
( ) Depression
( ) Panic Attacks
( ) None

5a) Do the above conditions respond to medication? ___Yes ___No

5b) For anxiety/panic attacks please indicate on average the frequency and length of attacks.
per day _____ per week _____ per month _____ per year ___ approximate duration _____

5c) Please describe the functional limitations caused by this impairment:
_____
_____

6) What disability **prevents** the applicant from riding the regular bus system? A detailed diagnosis is required. Please be specific. (Please do not use diagnostic codes).

7) How does this disability affect the applicant's functional ability **and** prevent him/her from riding the regular bus system? (Please explain in **detail**):

8) Is this condition: Permanent ( ) Temporary ( )
If temporary, what is the expected duration?_____(number of months)

9) Does the applicant's disability require that he or she travel with an attendant?

( ) Yes ( ) No ( ) Sometimes

10) Is the applicant able to travel to and from a bus stop?
( ) Yes ( ) No

10A) If no, please indicate all that apply:
( ) Cannot negotiate if the street or sidewalk is too steep.
( ) Cannot travel if there are no curb cuts.
( ) Cannot cross busy streets and intersections.
( ) Cannot locate bus stop due to a visual impairment.
( ) Cannot wait outside without support for 15 minutes.
( ) Easily becomes confused and may get lost.
( ) Other (please specify)_____

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SCAT APPLICATION MEDICAL FORM

11) Please specify the applicant's ability to independently perfom the following functions using the most effective mobility aid.

	Little or No Difficulty	Discomfort and/or some difficulty	Severe pain or impairment	Impossible or likely to cause a serious medical crisis
Find his/her way between familiar locations				
Handle money or tickets				
Give address and telephone number upon request				
Recognize a destination or landmark				
Ask for and understand directions				
Travel 200 ft. (city block)				
Travel ¼ mile (three blocks)				
Deal with unexpected situations or unexpected changes in routine				
Safely and effectively travel through crowded facilities				

Applications with illegible or incomplete information will be returned and deemed void.

I also certify that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis.

Signed this _____ day of _____, 20____

_____
(Name of Physician)

Please place Medical office stamp here.

_____
(Signature of Physician)

_____
(License Number)

_____
(Phone Number)

_____
(Street Address)

_____
(City) (State) (Zip)

Please note: Only the original forms of this document will be accepted.

SCAT PARATRANSIT APPLICATION FORM RECERT

APPLICANT'S CERTIFICATION, CONSENT OF RELEASE OF APPLICATION INFORMATION

I, the applicant, understand that the purpose of this application form is to determine my eligibility to use the SCAT System. I agree to release the information requested to SCAT and any eligibility review panel and understand that the information contained herein will be treated confidentially. I understand that SCAT reserves the right to request additional information at its discretion. By signing, I authorize the licensed medical professional who signed this application to use and/or disclose certain protected health information (PHI) about me to Suffolk County Office for People with Disabilities. The information will be used or disclosed for the following purpose: To determine eligibility to use the SCAT paratranist service.

I understand that my application will be returned if it is **not complete**. I confirm that all the information that I provide on this application is true to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to the revocation of my certification. I understand that a false statement made herein may result in the rejection of my application for Paratransit service.

I understand the application process can take up to 21 days from the time SCAT receives a completed application. If my application is returned for clarification or additional information, this can delay the process.

I agree to notify Suffolk County Office for People with Disabilities at 853-8333 if I no longer need Paratransit for any reason, including a change in my ability to use bus service. I also understand that failure to adhere to the policies and procedures for using Paratransit may be grounds for suspending or revoking my eligibility to participate in this program.

In the event that I apply for Paratransit eligibility in another community, I hereby authorize SCAT Paratransit to release the information on my SCAT application to such agency.

CERTIFICATION: The information I have given on this application is true to the best of my knowledge. **False statements are punishable under Section 210.45 of the Penal Law.**

_____

Signature of Applicant

_____

Printed name of applicant

Date

_____

Signature of preparer (if other than applicant)

Date

_____

Printed name of preparer, relationship or agency name

This application form must be completed and sent, together with 1" x 1 1/4" identification-type photos as described in the cover letter to:

SCAT
c/o Suffolk County Office for People with Disabilities
Bldg. 158, North County Complex
P.O. Box 6100
Hauppauge, NY 11788-0099
(631) 853-8333 (VOICE)
(631) 853-5658 (TTY)